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## ***Forms of Health Service Financing and Their Effect on the Provision of Care***

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### **Introduction: Primary Health Care**

Recent years have seen a growing concern over the rising costs of health care. This concern is linked with the question of the effects of particular forms of financing on the provision, organisation and utilisation of care, including all questions related to the quantity, distribution and quality of that care. The 1978 international conference on primary health care (PHC), through its Declaration of Alma Ata [WHO/UNICEF 1978], offered the basis for appropriate analyses and actions directed toward the internationally accepted goal of 'Health for All by the Year 2000'. It is obvious that such a goal/slogan need not be taken literally, and in fact many qualifications have already been offered to clarify its meaning. It is equally obvious that its very utopianism, in addition to being — in one sense — its strength, offers to governments and international agencies possibilities for extraordinary leeway and equivocation in its interpretation.

In its best definition the PHC concept begins with the wider economic, social and political dimensions of health development; that is, it recognises that improved national or community health indices are not dependent primarily upon the work of the health services. The adequacy of diet, availability of clean water and sanitation systems, levels of education and culture, democratic community and family structures which offer support to all their members, and so on, are far more significant to health indices than are health services *per se*. This perspective is based both on the historical experiences of today's industrialised nations and such Third World countries as China and Cuba, which have managed to achieve much higher health standards than have others with similar levels of average *per capita* income. It should be emphasised that the PHC approach is judged to be relevant to all countries, rich or poor, although with different specific applicability in keeping with different resource and other kinds of potential.

With regard to health services, which of course do have a contribution to make to improving health standards, the PHC approach requires ready accessibility (geographic, financial and social) and continuity of preventive action and curative care as needed. Because resources are always limited and not all health technologies can (or necessarily should) always be made available to everyone for everything, it is necessary to exercise control over the technologies being employed, and this control should result in both equitable and efficient health care in the context of broader positive social goals.

### **What Will PHC Cost?**

The question of the adequate financing of health care in relation to the structure of that care was referred to in the *Sixth Report on the World Health Situation* [WHO 1980] as follows:

It is certainly not a new idea to relate the availability of financial resources to the quantity and quality of available health care. However, what is now clear is that the availability of extensive funds for health care does not in itself ensure the existence of a system of care that will be accessible to all in keeping with priority needs, as seen both by the health workers who provide the care and those who receive it. The cost explosion in health care in a number of industrialised countries has been partly responsible for a re-examination of the relationships between the growing volume of expensive health care — particularly hospital inpatient care — and improved health indices. There is a growing consensus that additional expenditure on health care, at least in the developed countries, is not bringing about a commensurate improvement in health. It is now widely agreed that a pattern of spending that is heavily biased towards technically sophisticated inpatient care is inappropriate, even in wealthy countries with their own particular disease problems. The issue is still more clear-cut in the case of low income countries. A growing

understanding of the issues involved has led to a search for ways of financing health care systems that will be more cost-effective. Studies of the financing of health care systems are being extended by examination of the relationships between particular forms of financing and the provision of care in keeping with the priority need for primary health care coverage of the whole population.

The special concern here is this 'examination of the relationships between particular forms of financing and the provision of care in keeping with the priority need for primary health care coverage of the whole population'. It is clear that different methods of financing health care will have different effects on the coverage of various sections of the population and their consequent capacity to utilise the services being offered. These different methods of financing care will affect not only the amounts raised (which have tended to be the focus of much past interest in health sector financing, ie 'the more the better'), but the ways in which the services are organised and managed at all levels of the health care system: who is included or excluded from particular types of care, the levels of efficiency ('productivity') achieved by the system and — especially important — the technological choices being encouraged in the delivery of health care.

Implicit in the approach outlined above is the concept that costs (in this case of PHC) are not something that is given or fixed; rather, costs will be determined by choices made over the organisation, composition and management of health services. Appropriate choices in technology (buildings, equipment, pharmaceuticals, manpower, management, etc) are basic for any possibility of creating low cost, affordable, equitable and efficient health care systems capable of supplying the whole of populations with PHC. Such choices, however, also include those to do with financing the services. This implies conscious policy and planning decisions which will make the methods of health care financing dependent on the type of health care system that is desired: at present, in many countries the type and cost of services are allowed to be determined substantially by the methods of financing them.

Such an approach also accepts the fact that more health sector resources alone will not ensure that health development is based on an appropriate PHC system. If PHC is to become a reality, particularly in low income countries, the choice of methods to finance health care should be dictated by the aim of developing an affordable health care system which is available to the whole of the population. The question 'what will PHC cost?' will have to be answered by 'what we can reasonably expect to have is what it will cost'! The answers to such questions — and indeed the choice of questions in the first place — will determine

the nature of the health care system. It may be one which makes advanced technology available only to a minority, or one which makes basic health technology available to all, but offers only limited scope at the top end of the technological scale. In practice, such stark choices are usually not necessary as resources are more often than not sufficient to provide tolerably high levels of technology for all, provided those resources are well managed and employed. The decisions on such questions will be taken in the context of the political perspectives of countries and prevailing views about the determinants of good health.

## **Paying for Health Services**

There exists an extensive literature concerned with the sources of finance for different types of health service activities, as well as with accounting and other problems connected with the identification and measurement of these sources [Abel-Smith and Leiserson 1978, WHO 1978, Zschock 1978]. The central policy issues which arise in connection with the appropriate choice of methods for financing health care were discussed in the WHO/UNICEF joint report to the Alma Ata conference [WHO/UNICEF 1978]. Paragraphs 112 and 114 read:

In [earlier discussion] mention was made of the essential decision to give preferential allocation of resources to primary health care and its supporting system. Account has to be taken of any community participation in financing community services, but in most countries financing is likely to be a combined community and government effort, with the government in the final analysis having to ensure that it is adequate for the programme agreed on. Finance for health care may come from government taxation, or from a social security system, with contributions from individuals or employers or both, and it may also come from philanthropic sources or through payment by individuals. However, for developing countries to rely solely on methods of financing health care that are current in more affluent countries will be as unwise as to rely on the technology practised in those countries. Thus, the coverage of primary health care costs through national taxation may be quite impracticable and totally inadequate in predominantly agricultural societies. Also, the classical social security systems applied in some of the industrial countries may, in developing countries, tend to favour very limited population groups and thus lead to discrimination against the majority of the population. Individual payment on a fee-for-service basis is certainly not a solution that can be widely applied. In addition, such social security and private methods of payment may be totally inapplicable to some vital components of

primary health care that are not concerned with direct service to individuals, such as the provision of potable water, the protection of houses against insects and rodents, or health education in all its aspects.

Where all health services are provided by the government it is possible to control not only the organisation and budgeting of primary health care but its financing too. Where the health system is composed of multiple agencies, it is important to coordinate the resources as well as the efforts of all of them and to induce them to lend their weight to primary health care and its supporting structures.

This statement is cautious, but nonetheless clearly implies the desirability of an integrated, publicly controlled health care system. Extensive international experience has shown that integrated health care systems are more likely to control costs appropriately and be efficient in terms of health care outputs relative to resource inputs. An integrated system recognises the existence of only one national pool of health sector resources and will work towards decreasing any differentials in access which may exist between various social and geographically-based population groups. Integration implies a strengthening of public sector health care and a weakening of private sector medicine. It also provides the basis for appropriate supporting links among community PHC activities, the basic health services, and the higher referral levels, at least partly by linking community self-financing with government resource allocations to the various parts of the health care system. It also increases the possibilities for intersectoral collaboration in support of health activities.

Serious problems in implementing the goals of PHC are likely to occur to the degree that there exist separately financed, selective health projects/programmes/services directed toward delimited populations. Such delimitations may take the form of selectively insured population groups (eg wage workers in larger industrial establishments), or people with sufficient income to purchase privately one or another kind/level of medical care, or the population contained within the area of an externally financed pilot project, or 'target' populations in vertical disease control programmes such as those for malaria or river blindness. In addition, some definitions of PHC are based on the selection of a limited group of activities developed as a discrete package of inputs to an essentially unintegrated health care system (unintegrated both as to financing and service delivery) and directed toward 'target' population groups. Both national governments and international agencies have been responsible for these types of distortions of the

basic PHC concept. This is not to argue that specific programmes directed toward particular objectives are never to be developed, but when they are, they should remain part of the overall system and only use resources in ways which will not jeopardise an overall and balanced set of health priorities.

There is widespread agreement about certain of the effects which follow from particular methods of financing health care; for example, the fact that because those who provide funds expect to control the ways in which they are spent, it is more difficult to achieve a unified and coordinated health policy when financing comes from multiple sources; that the use of private health insurance and flat-rate user charges tend to have a regressive influence on income distribution and usually on health service utilisation as well, and that such systems are generally heavily biased towards curative and urban care; that similar, if less marked, effects follow from social security systems; that publicly provided, unified health care systems financed out of general tax revenues tend to be the more progressive in their effects on income distribution and the equitable utilisation of health services, as well as being at least potentially less biased toward urban and curative care, and that they generally offer better instruments of control over the costs of health care. It should be stressed, however, that although the principles of such issues are well established in public health thinking and sometimes even in practice, the scope for progress in implementing them can only be determined in the context of the precise conditions of individual countries.

### Going Round in Circles

The methods by which health services are financed are thus basic determinants of their quantity, quality and distribution and therefore of their impact on people. These questions were discussed, under the title 'Financing of the health sector', 14 years ago at the technical discussions of the 19th meeting of the Pan American Health Organisation held in October 1969 [PAHO 1970]. The conclusions reached there are still applicable; in addition they offer a concise and valuable summary of key issues. After agreement that financing is an important aspect both of the diagnosis and of the planning of the health sector, it was pointed out that in general countries (in the Americas) did not have an accurate knowledge of how the health sector was financed, primarily because budgetary and accounting data were unavailable or not properly used; however, techniques were already available for making a complete study of the problem. It was then noted that the relative scarcity of funds for the health sector, and the lack of coordination by the multiple sources and institutions responsible for them, resulted

in overlapping and deficient utilisation of these funds. The attempt by various health sector institutions to gain priority status in the distribution of funds hampered the achievement of a solution to the problems. A particularly significant conclusion was reached when it was agreed that a 'reorganisation of the institutional structure of the health sector is therefore urgent. This would result in an increase in productivity, which is more important than a mere increase in sectoral financing'. Additional conclusions reached at these technical discussions included the observation that the different mechanisms utilised for distributing funds to the health sector and its institutions did not provide the basis for rational decision making; also that it was impossible to measure accurately the effect of health activities because of the lack of proper indicators. The view was expressed that the basic purpose of expanding the internal financing of the health sector should be to extend geographical coverage and to include population groups not currently enjoying continuity of service. The last conclusion reached by the meeting was that 'the financial resources at present available to the health sector cannot satisfy the growing demand for services; at the same time, any increase in external or internal financing should be used to deal with problems in a rational manner; that is, with due attention to priorities and by means of technically sound projects that reflect a well-defined health policy, thereby enabling optimum use to be made not only of funds, but also of manpower and physical resources in health sector institutions'.

Fourteen years after that meeting the situation remains basically the same in all but a handful of countries. Perhaps just because things have changed so little, international agencies continue to sponsor meetings which keep covering essentially the same ground. What is particularly disturbing about many of these meetings and related activities is that they seem so often to start once again at the beginning, debating issues of principle that have long been resolved by public health workers. As would be expected, this phenomenon relates to the stubborn resistance to the principle of publicly controlled health care systems which is being waged by private sector medicine everywhere. Such forces are especially strong in the United States, from whence they are able to bring disproportionate influence to bear internationally through the extensive activities and singular power of the US in all international arenas, including those related to the health sector.

### **Adequacy and Use of Public Sector Funding**

For many health ministries the implementation of PHC is understood to be basically dependent on

additional resource inputs; that is, it is assumed the existing system will go on more or less unchanged while additional activities labelled 'primary health care' are added. At the same time, for many finance ministries — often under international banking pressure — and for some international agencies, the implementation of PHC is understood to require no (or very few) additional resources, or even a reduction, in real terms, of the allocations currently being made to health ministries. In these situations, by implication if not explicitly, health care is expected to remain or become an essentially private transaction between providers and consumers, thus relieving the state of its responsibilities in this area except for some carefully selected activities.

Developments of this sort can be seen in many of the industrialised countries, as well as in the Third World. In the United States sharp concern is being expressed by public sector health workers and their natural constituency — those most dependent on them for care — over the actual and threatened loss of many important public health care institutions. From the mid-60s to the 1970s these institutions and the people they served saw an increased flow of public sector resources, primarily in the form of Medicare and Medicaid funds, channelled into private sector institutions to the relative detriment of the public sector. At the same time these same public sector institutions were losing their traditional bases of fiscal support in the cities and states, as a result of increasing budgetary constraints at these levels of government. In the name of cost containment it now appears that Medicare and Medicaid funds will also find themselves under pressure, as will many smaller 'less efficient' private sector institutions. By contrast, the institutions likely to suffer the least will be the larger 'corporatist' private facilities, like university-linked institutions, conglomerate hospital chains, and 'leading' research centres. The conclusion reached by many public health professionals and activists is that the current political-economic crisis in health care (which was created in the first place by policies which favoured the private health care sector, and its major beneficiaries) will now be 'solved' primarily by squeezing those groups with the least capacity to resist — in particular the poor and the ethnic minorities.

Within the context of the broader PHC approach, the question of the availability of material resources may not by itself be of unique significance. Nonetheless, there can be little doubt that most Third World countries would benefit from higher overall levels of health sector expenditure and indeed the higher overall levels of income that might bring this about. However, these higher income and expenditure levels (overall and in the health sector) will require far more

appropriate distribution and use than is currently the case, if they are to have a significantly positive impact on the health status of the mass of population.

### **The Contributions of the Community**

From the early 1970s, and coincidental with the development of the 'basic needs strategy', there has been a good deal of rather easy talk — especially in international circles — about the potential contributions of communities to PHC and other related areas of 'basic needs'. Communities, usually rural and poor, were often expected to make these contributions even in the absence of any clear government activities on their behalf, not to speak of possible government actions directed against them. The capacity of peasant communities to care for many of their own needs was 'discovered' in the aftermath of the Chinese 'opening' and it was assumed that the mechanics of community self-reliance could be transplanted to countries which were politically and economically very different from China.

It should go without saying that the prime goal of raising local resources ought not to be to relieve national governments of their central responsibility for the health of the entire population of the country. Implementation of the PHC approach should mean that additional financial resources would be allocated by health ministries for community level health activities. These resources would flow either from expanded health ministry budgets, or most likely some combination of both. The provision of additional financial resources from national governments to communities for some activities may be done direct to communities on a *per capita* basis, rather than only as payments to health service staff or for supplies, as the former may strengthen local control over the use and management of these additional resources. In the course of developing PHC, information should be generated on the relative size of the resource contributions being made by the various levels of government and by communities, as well as by different groups within the community. Corresponding information is necessary concerning the division of benefits from PHC development which accrue to the various groups comprising the overall community.

Resources additional to money flows will have to be made available to the social periphery if PHC is to become a reality. Acceptance of the PHC perspective implies the organisation of the entire health care system to provide support for PHC. This will mean closer links between the existing health care institutions and the growing PHC network at the periphery. These links would encompass all types of referral and support activities especially those

undertaken from health centres and rural or district hospitals. Without these, community level activities cannot be sustained.

The extent of community contributions to the development and support of PHC activities is likely to be related directly to the community's capacity to influence decisions with regard to those activities. Control over funding, or voluntary labour inputs, and control over other decision making are complementary functions. Community control over local PHC activities also offers, at least potentially, the best guarantee of their successful development. To be successful PHC will have to make use of technologies which result in services that are available to the whole of low income populations. Community control over its own contributed resources, and effective community influence over the resources contributed by the government, should help to ensure that appropriate technological choices will be made, and that the resources will be used in an equitable and efficient manner.

There are many ways in which the community can participate in the different stages of PHC development and implementation, from the definition of problems and the setting of priorities, through the planning and implementation of the entire range of locally based PHC activities. It is in the course of such participation that judgements can be made which will determine the nature, cost and utilisation of PHC activities: judgements concerned with such activities as labour contributions to construction, the training of village health workers, collaboration with traditional healers and birth attendants, and the creation of local social insurance funds. It is the net results of such decisions which determine the basic costs of PHC.

In addition to its contribution to the management of PHC, the community can, for example, contribute labour for the construction of clinics, pit latrines and supplies of clean water, and participate in programmes for the control of vectors (eg mosquitoes, snails). Another important form of labour contribution by the population is the community health worker. If these health workers come from the community in which they live and are truly chosen by it, they will be more likely to have its moral and material support.

One other critical area of community participation is the raising of additional material resources, in cash or kind; a few examples will be offered here. One fairly common method is special contributions of money or materials, usually on a once-only basis, by members of the community. Obviously this method is of only limited usefulness. Another common method, perhaps the major one, is user-fee payments at the time of

illness. This tends, however, to reproduce most of the problems of conventional systems of fee paying for health care, especially their curative orientation and episodic character.

By contrast, potentially the most successful way of financing PHC at community level is through the development of various sorts of social funds. These can be based upon forms of communal production (as in China), community taxation schemes, or savings and loan cooperatives. These funds, in cash or kind, can be used as payment to community health workers, or for the purchase of drugs and other supplies. Another possibility is that of family or self-help insurance groups based upon monthly prepayments (as in the 'Savar project' in Bangladesh). Finally there is the possibility of a mixed system based on a social fund, which contributes to the upkeep of a community health worker and may pay for the initial purchase of a stock of drugs, but with user fees to cover the cost of replacing the drugs on the basis of a revolving fund (as in Ethiopia). A similar arrangement might be worked out based on family or other voluntary association insurance schemes.

### Conclusion

The best definitions of PHC are based on an understanding of the deep-rooted relationships between community, socioeconomic conditions and health. These are complex relationships and — even in the relatively few situations in which the political environment allows PHC to be more than a slogan — too little understood to make for easy imple-

mentation of the concept. Nonetheless, at least one thing seems fairly certain: in the absence of participatory democratic structures it is unlikely that healthy societies can be created. This is more obviously the case in economically poor countries, but in a deeper sense true also for rich ones. 'Health for All by the Year 2000' is obviously unattainable in any literal sense, but in its broadest and best sense is certainly a more desirable goal than, say, just to raise the economic growth rate by a few percentage points — although these should not be mutually exclusive goals. Perhaps the most important contribution of the PHC approach is that it offers — again, in the best and broadest sense — a fuller definition and view of development (not just growth), and the processes by which the latter might be achieved, than has been available generally in the recent past.

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